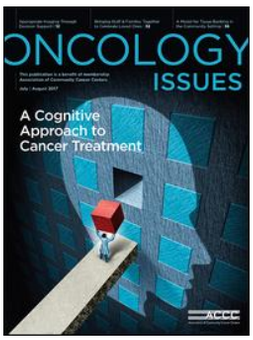

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Highlights From the ACCC Fall Leadership Conference

The 1992 Fall Leadership Conference, Oncology Economics IX: Moving Toward the Future in Cancer Care," in Coronado, CA, presented attendees with the most up-to-date information available on an array of issues that impact cancer care providers.

Work Proceeds on APGs

The consensus is that "some form of payment system based on ambulatory patient groups (APGs) will be implemented in 1994," according to Joanna Lion, Ph.D., Principal, Lion Associates, Cambridge, MA, noting that HCFA is "under the gun from Congress to control outpatient health care expenses." In fact, a demonstration project in which hospitals will be paid for outpatient expenses on an APG basis is about to begin in both New York and New Jersey, and the Department of Defense is working on an APG-type system for use in the government's Champus insurance plan. As far as private insurers are concerned, Lion predicted that although they will tend to modify the proposed APGs for Medicare, "an APG-based payment system will move into the private sector faster than the DRG system did."

There are some major implementation concerns for a number of specialities, including oncology, according to Lion. The APG payment system being proposed by 3M/Health Information Systems is "strictly CPT-4 based; it doesn't recognize HCPCS codes. In addition, HCFA never included 'J' codes on the UB82 hospital outpatient billing form, so it doesn't have any data on chemotherapy drug payments, costs, or chemotherapy supplies in the outpatient setting," she said. As a result, Lion believes that "only minor oncology-related procedures, such as biopsies and scopies, will be included in the first stage of implementation."

ACCC Honors Dr. DeVita

Vincent T. DeVita, M.D., receives ACCC's Annual Award for his many contributions to the advancement of community-based clinical research from ACCC President Robert T. Clarke, M.H.A. Dr. DeVita, former director of the NCI, was the champion of the CCOP and CGOP programs that first allowed community-based oncologists and hospitals to participate in clinical research.

An Update on RBRVS

"There is significant hope that separate payment for a push and an infusion during the same visit will be reinstated in the Medicare fee schedule," said A. Collier Smyth, M.D., President, Northern New England Clinical Oncology Society, Hooksett, NH, and a member of ASCO's Clinical Practice Committee. Medicare's present official policy disallows payment for multiple pushes or a push and an infusion during the same visit. Citing a recent ASCO study of typical medical oncology practice costs for chemotherapy services, Smyth said that "only 22% of all pushes can be reimbursed." In short, "Medicare covers about one-half of the costs of chemotherapy administration in the office setting." However, he does not believe that the final rules, due from HCFA in November, will allow for multiple pushes.

Smyth also predicted that there will be a chemotherapy management code in the final rules. "It will probably be evaluated as part of the Evaluation & Management (E&M) codes. However, there is concern because it doesn't fit into the descriptors of the new E&M codes. Therefore, we may see a different code developed specifically for chemotherapy management, and it may well be in the form of one code for hospital-based services and another for office-based services, the latter of which would include the cost of supplies as part of the practice expense of the RVU." But oncologists should be warned, Smyth said, of the potential temporary hassle factor this could create with regard to reimbursement. "There is the fear that during the time between HCFA's final rule and the actual creation of a new CPT code by the AMA, oncologists will have to convince Medicare carriers that chemotherapy management is, indeed, a reimbursable service.

OR Commissioner Defends Medicaid Plan

The Department of Health and Human Services' (DHHS's) decision that Oregon's Medicaid reform plan violates the Americans With Disabilities Act "is not a roadblock, but a bump in the road," contended Richard Wopat, M.D., Commissioner, Oregon Health Services Commission, Lebanon, OR. "The DHHS didn't criticize the content of the plan, but the process,"

Wopat pointed out. "We are readjusting the list to remove all references to quality of life, and we will be re-analyzing the complete list of ranked services and re-submitting it within the next four to six months."

Oregon's plan is to expand Medicaid coverage for a broader range of low-income people, but to limit covered services based on pairs of treatments and conditions and on available state funding for the Medicaid program. Currently, the state plans to cover 587 of the 709 condition-treatment pairs prioritized by the Commission. "Services and procedures are ranked based on the benefit of the treatment, the benefit to society, and the cost of the treatment," Wopat explained. For instance, he said, "pneumococcal pneumonia was ranked first out of 709 line items because it is highly fatal and highly treatable.

As far as malignancies are concerned, Wopat said, "We excluded late stage, incurable cancers; that is, those with less than a 10% chance of survival for a period of five years. In those cases, we will provide services and items for comfort and pain relief." However, he says, "if a treatment falls below the line, that means the state won't pay for it; not that the patient can't have the treatment." When a member of the audience brought up the fact that under such a proposed cut-off for malignancies it is conceivable that no-one with ovarian carcinoma would be treated, Wopat explained that technical adjustments will be made on an ongoing basis. "It may be that specific conditions will be ranked as separate line items." He also conceded that "five-year survival may not be the right timeframe; maybe it should be three years. We know this approach is not perfect, but we do believe it is a step toward a more equitable and accessible health care system. Health care is not necessarily synonymous with health," he maintained. "Some services are better and more effective than others."

Pain Control Initiatives on the Rise

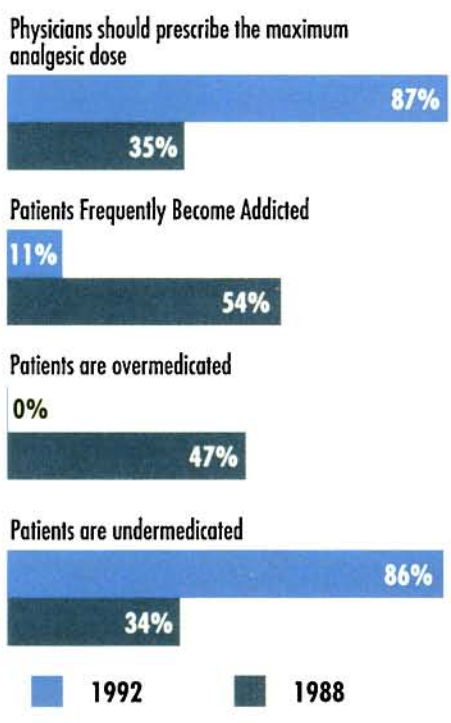
Recent studies show that it is "too common for the pain of cancer to be undertreated," according to June Dahl, Ph.D., Chair, Wisconsin Cancer Pain Initiatives, and Professor, University of Wisconsin School of Medicine, Madison, WI. A study at the University of Wisconsin's Comprehensive Cancer Center showed that "less than 50 percent of the patients at the center were receiving good pain relief," Dahl said. In addition, a survey of almost 1,200 physicians by the Eastern Cooperative Oncology Group (ECOG) found that 49 percent of oncologists believe that the quality of pain relief is fair or poor, and 40 percent say that cancer pain is not being adequately treated.

Inadequate knowledge on the part of health care professionals, patients, and the public at large is a major "barrier to pain control," Dahl maintained. "Medical students receive little training in pain assessment and management, and they also lack knowledge of the pharmacology of analgesics. As a result, they have unnecessary fears about narcotic side effects." The ECOG survey showed that, in the clinical setting, oncologists cited three major barriers to pain management: poor pain assessment (76%); patient reluctance to report pain (62%); and patient reluctance to take pain medications (62%). "We must clarify the facts about addiction," Dahl stressed. "Addiction is a behavior and should not be confused with tolerance and withdrawal."

However, progress is being made. "There is a growing national movement to improve relief of cancer pain," Dahl said. "Currently 28 states have organized cancer pain initiative programs in which education and advocacy are key elements. Voluntary, grass-roots organizations are spreading the message that cancer doesn't have to hurt; patients won't become addicted; and patients need to talk openly about their pain with physicians, nurses, and pharmacists.

At the University of Wisconsin, changes in the curriculum of the medical school and pain management educational materials are showing encouraging results, according to Dahl. Two surveys of the medical students, conducted in 1988 and 1992, demonstrate that today's students have a much greater understanding of the need for pain management (see the table on this page). To that end, Dahl encouraged teaching hospitals to examine the cancer pain curriculums and guidelines for medical schools that are being developed by the American Society of Clinical Oncology.

What medical students believe about pain management



NSAPB Releases Tamoxifen Trial Statistics

As of late September, 1,600 women had been randomized on the National Surgical Adjuvant Breast and Bowel Project's (NSABP's) breast cancer prevention trial and 1,559 women were actually on trial, reported Carl G. Kardinal, M.D., Principal Investigator of the CCOP at Ochsner Clinic and Foundation, New Orleans, LA. Citing data received from Bernard Fisher, M.D., NSABP's Project Chairman, Kardinal reported that 28,836 risk assessment profiles had been submitted by a total of 271 primary and secondary participating centers—67% of which are potentially eligible to participate in the trial. However, "with the number of patients in the pipeline, the number of women on trials is expected to double," Kardinal said.

Nevertheless, nationwide only five percent of eligible women are going on trial. To explain this reluctance, Kardinal provided some statistics from his own institution. "We obtained 813 profiles; 400 women were determined to be eligible for the study; 34 are still being consulted; 36 are on trial; and 252 eligible women declined to participate." According to Kardinal, the reasons for not participating in the study include financial concerns, reimbursement denials by insurance companies, the desire of many women to continue estrogen replacement therapy, and fears about tamoxifen's side effects.